Constipation in Children

The guidelines below should be used to assess all infant WIC applicants whose caregiver express concerns about constipation in addition to the Infant Nutrition Management guideline. Elements indicated by an asterisk (*) are optional and not required to assess WIC eligibility.

DEFINITION: A child over one year of age who demonstrates slow passage of feces through the colon, usually characterized by hard, dry stools with evacuation occurring irregularly and/or infrequently.

RATIONALE: True childhood constipation is a concern whose existence can impair appetite and lead to further health problems in the child. The lack of a daily bowel movement is insufficient criteria for defining constipation. Stooling frequency varies by individual.

MANAGEMENT:

1.0 GOAL: To provide nutritional support to foster complete evacuation of the colon and to prevent the occurrence of constipation in the future.

2.0 GUIDELINES

- 2.1 Constipation can over time cause health problems for the child and decreased appetite. The decreased sensitivity of the defecation reflex and the distention of the rectum and colon can lead to long term difficulties with stooling in the child.
- 2.2 The presence of encopresis (incontinence of feces not due to organic defect or illness) may be caused by the watery contents of the bowel leaking around hard retained stools and may be mistaken for diarrhea.
- 2.3 After physician directed treatment for constipation, the child should be encouraged to consume a well balanced diet, high in fiber and fluids that assist in regular, normal bowel movements.

3.0 NUTRITIOAL ASSESSMENT

- 3.1 Fiber content of diet: intake of whole fruits, vegetables, and whole grain products;
- 3.2 Adequacy of fluid intake (particularly water and fruit juice) for soft stool formation;
- 3.3 Excessive intake of milk or dairy products. Dietary residue such as calcium salts in cow's milk tends to make the stools firm;
- 3.4 Pica substances such as clay or dirt;
- 3.5 Intake of supplemental iron, vitamins and minerals.

4.0 CLINICAL ASSESSMENT

4.1 Evaluate stooling pattern. Consider frequency, consistency, and amount. Assess the regularity of bowel habits. Is there withholding of defecation due to environmental concerns such as the child's embarrassment to use child care or public rest rooms?
4.2 Determine whether toilet training has begun.
4.3 Assess use of methods to relieve constipation (mineral oil, laxatives, suppositories, herbs, enemas).
4.4 Evaluate past medical history that could affect stooling patterns (i.e. anorectal malformations, anal fissures, Down Syndrome, Cerebral Palsy).
4.5 Determine exercise and activity level.
4.6 Assess the presence of encopresis (leakage of watery contents from the colon around a hard retained stool; sometimes mistaken for diarrhea).

5.0 COUNSELING

5.1 Explain that supplemental iron in high doses may cause constipation in some individuals.
5.2 Diet Counseling
5.2.1 Encourage increased intake of whole grains and cereals, dried beans, raw or dried fruits and vegetables, and nuts and seeds as age appropriate.
5.2.2 Explain that nuts, seeds and other fibrous foods may cause choking in very young children and may need to be avoided or used cautiously.
5.2.3 Encourage the caregiver to give at least five servings of fruits and vegetables daily to the child with emphasis on whole foods.
5.2.4 Explain that high fiber foods should be added gradually to the diet over a two to three week period to reduce flatulence and bowel discomfort.
5.2.5 Urge increased fluid intake, especially water and juices.
- Explain that fluid needs vary according to age, size, and activity level of the child.
- Suggest that prune juice, approximately 4 ounces be consumed two to three times a week.
- Apple juice and pear juice contain sorbitol may also act as a mild laxative in some children.

5.2.6 If milk and dairy product use was seen to be excessive in the dietary assessment, suggest limiting their intake to the recommended level for the child's age.
5.3 Clinical Counseling
5.3.1 Explain that normal frequency of stooling varies with age and diet.
5.3.2 Discourage the use of laxatives, suppositories, mineral oil, herbs, or enemas that may lead to dependence and

bowel muscle atrophy. Note: If mineral oil, suppositories, or laxatives are prescribed by a physician, the recommendations should be followed, however emphasis that the goal is to develop good dietary habits and not dependence on laxatives and mineral oil.

5.3.3 If toilet training has begun, encourage proper toilet training techniques that are age and developmentally appropriate to the child. Emphasize regular times for bowel movements, preferably after a meal.

5.3.4 If applicable, discuss the use of public or day care rest rooms, and encourage caregivers to work with teachers and others to overcome the child's fear or embarrassment.

5.3.5 If the child has special health needs that effect stooling, counsel on issues appropriate to that particular developmental concern.

6.0 REFERRAL/FOLLOW UP

Refer to physician when symptoms of impaction or chronic constipation are present.